CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155266	B. WIN			09/23/20	)11
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			PY RUN AVENUE		
LIFE CAF	RE CENTER OF FO	ORT WAYNE			VAYNE, IN46805		
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(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
					This Plan of Correction is the center's credible	,	
		r a Recertification and	F0	000	allegation of compliance.		
	State Licensure Survey.				Preparation and/or execution of this plan of correction does not constitute admission or		
					agreement by the provider of the truth of the f alleged or conclusions set forth in the state of		
	Survey dates: So	eptember 19, 20, 21, 22,			deficiencies. The plan of correction is prepare and/or executed because it is required by the	d	
	& 23 2011				provisions of federal and state law.		
					We respectfully request the ISDH accept paper compliance as evidence of compliance with	er	
	Facility number:	000167			federal requirements for participation in the Medicare and/or Medicaid programs in place	of	
	Provider number				a revisit survey.	-	
	AIM number: 10						
	Alivi liullibet. It	00273740					
	g .						
	Survey team:						
	Rick Blain, RN						
	Sue Brooker, RE	)					
	Sheryl Roth, RN						
	Angela Strass, R	N					
	Census bed type:	•					
	SNF/NF: 77						
	Total: 77						
	Total. //						
	C						
	Census payor typ	pe:					
	Medicare: 11						
	Medicaid: 58						
	Other: 8						
	Total: 77						
	Stage 2 sample:	34					
	These deficiencies reflect state findings						
		nce with 410 IAC 16.2.					
	cheu in accordal	ice with 410 IAC 10.2.					
	0 10	1 / 10/20/11					
	Quality review c	ompleted 9/28/11					
LABORATOR	V DIDECTORS OF BROKE	WIDED (CLIDDLIED DEDDECENTATIVE)C CL	CNIATUDI	,	TITLE		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

1U7V11

Facility ID:

000167

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE ( COMPL 09/23/2	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	1649 SF	DDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE VAYNE, IN46805		
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F0248 SS=D	The facility must p program of activitie accordance with the assessment, the ir mental, and psych resident.  Based on observative record review that 1 of 3 sampled regroup activities of met the criteria formet the criteria for	rovide for an ongoing es designed to meet, in ne comprehensive interests and the physical, osocial well-being of each ation, interview and efacility failed to include esidents (Resident #67) in of the 10 residents who or activities.  Inical record for Resident to 9:25 a.m., indicated the oses included, but were own's Syndrome and in.  In of Resident #67 was 1/20/11 at 11:08 a.m., riew she indicated is not taken to activities for.	F0	248	F 248 Activities Meet Interests/Needs of Each Resident (#67) was reassessed by Activities Director and novinvolved in group activities of choice.  An assessment of every residents last change of condition was completed on 10/10/11 by the Activities Director.  Weekly Activities staff meetings initiated to relay information. Activity were in-serviced on 10/7/11 by the Executive Director of the need to assist resident (#67) to group activities. Quarterly assessments of chewill include interdisciplinary team to ensurare coordinated among departmental Activities Director will community audit of care plans weekly X 90 days to encompliance. based on MDS schedule and significant change and reported	e Aides arts arts plete	10/10/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			LDING	NSTRUCTION  00	(X3) DATE COMPL 09/23/2	ETED	
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE VAYNE, IN46805		
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	group, morning sentertainment. To indicated Reside independent activity and family required escorts. The most current Resident #67, das current activity panimals/pets, arts cards, community programs, exercing group discussions reading, religious studies, sing-alor television, and we have a facility Minimal Activity Progressed dated 5/24/11, in music and television and television and television indicated Remorning stretch, special events, and religious services further indicated receiving 1:1 vision A facility care pl	t Activities Evaluation for ted 5/13/10, indicated preferences of scrafts, beauty/barber, youtings, educational se, family/friend visits, movies, music, radio, se services, religious ng, social/parties, ralking.  The Progress Note esident #67, dicated she enjoyed sion. The Progress Note esident #67 attended musical entertainment, rets and crafts and se. The Progress Note Resident #67 was not its at that time.			concerns. Findings will be brought to the PI Committee monthly with tracking and trending discussed. A goal o 100% compliance with care planning of activities X90 day be achieved. Once 100% compliance is achieved, PI Committee will then monitor quarterly to assure continued compliance.  •Date of Completion: 10/10	f ys will	
	resident was ofte	dicated the problem of en loud and disruptive Approaches to the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			ILDING	NSTRUCTION  00		(X3) DATE SURVEY COMPLETED - 09/23/2011		
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	э. үүн		DDRESS, CITY, STA	TE, ZIP CODE		
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	RE CENTER OF FO			<u> </u>	VAYNE, IN46805	)		
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1710		d, but were not limited to,		1710				DATE
	•	portunity to express						
	opinion of activities attended, offer							
	•	s directed toward specific						
		ent, transport resident to						
		ndependent activities						
		terests such as flash						
	* * *	imals, Spiderman and						
	· ·	gs to hold in her hands,						
	_	dent from activity if						
		ceptable to others.						
		1						
	An Activity Prog	gress Notes for Resident						
	#67, dated 8/23/							
	•	f via wheelchair and						
		o activities. The Activity						
	Progress Notes a	also indicated Resident						
	_	tended group activities						
	such as morning	stretch, arts and crafts,						
	sensory group, c	ooking group, religious						
	services, women	s's group and special						
	events/parties. 7	The Progress Note further						
	indicated Reside	ent #67's independent						
	activities include	ed movies, television,						
	friend/family vis	sits, visits from peers and						
	staff, and listening	ng to music.						
		lan for Resident #67, with						
		11/11, indicated the						
	*	need of individualized						
		oaches to the problem						
	· ·	ere not limited to, sensory						
		rities will be offered and						
	small sensory gr	oups.						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	1U7V11	Facility I	D: 000167	If continuation sh	eet Pa	ge 4 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			LDING	NSTRUCTION  00	(X3) DATE COMPL <b>09/23/2</b>	ETED	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		DDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE	-	
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	9/22/11 at 1:56 phe indicated Res with individualize to continue with participation in gindicated activity for recording the #67 on the Indiv Participation Recindicated the letter participation, the participation, the and the letter U in A facility Activity September 2011. Director on 9/22 indicated the followorning stretch (name document Bingo at 3:00 p.i. stretch at 9:30 a. and dining room and 9/22/11, senichapel at 10:00 at 2:00 p.m.  A facility Individuality Individuality Individuality Individuality Participation Received Participation Participation Received Participation Received Participation Received Participation Received Participation Participation Participation Received Participation Par	er A meant active eletter P meant passive eletter R meant refused, meant unable. ties Schedule for provided by the Activity					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		Ì	LDING	nstruction 00	(X3) DATE ( COMPL 09/23/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
					PY RUN AVENUE		
	RE CENTER OF FO			<u> </u>	VAYNE, IN46805		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
		pated in exercise on		-			
		sively participated in					
		on 9/20/11 and 9/21/11.					
	• •	n Record also indicated					
	_	icipated in movies, music,					
	radio, and televis	sion in her room on					
	9/20/11 and 9/21	/11. The Participation					
	Record did not in	ndicate Resident #67					
	refused to attend	music with (name					
	· · · · · · · · · · · · · · · · · · ·	9/20/11 at 10:00 a.m.,					
	_	1 at 2:00 p.m., and trivia					
		:00 a.m. No entries had					
		e Participation Record for					
		nt #67 was not observed					
		the scheduled activities					
		rning stretch at 9:30 a.m.,					
	`	e documented) at 10:00					
		at 2:00 p.m.; 9/21/11,					
		at 9:30 a.m., and trivia at					
	· ·	/11, sensory group at 9:30					
		Chapel at 10:00 a.m., and					
	horseshoes at 2:0	JU p.m.					
	Activity Assister	nt #2 was interviewed on					
	1	o.m. During the interview					
	she indicated act	_					
		ring the residents who					
	_	ice with transportation to					
	activities.	The manipolation to					
	The Director of	Nursing and the Activity					
		terviewed on 9/23/11 at					
	9:45 a.m. Durin	g the interview they					
	indicated Reside	nt #67 had been ill in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155266	B. WING		09/23/2011
NAME OF F	PROVIDER OR SUPPLIER	R		T ADDRESS, CITY, STATE, ZIP CODI	E
	RE CENTER OF FO		FORT	SPY RUN AVENUE WAYNE, IN46805	
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	June, 2011 and s	spent most of her time in			
	1	indicated the facility had			
		Resident #67 into group			
	activities since h	ner health had improved.			
	A facility "Resid	lent Admission			
	_	ted 2002, indicated "The			
	Resident has a ri	•			
		stent with his or her			
		ments, and plans of			
	care"				
	3.1-33(a)				
	3.1-33(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A DULL DING  00			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155266	A. BUILDI	ING		09/23/2011	
		133200	B. WING			03/23/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE  Y RUN AVENUE		
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(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
	A facility must use	the results of the	1	IAG	DEFICIENCE)		DATE
F0279 SS=D	assessment to dev resident's comprel	velop, review and revise the nensive plan of care.					
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan for 1 of 3 residents reviewed for dental concerns (Resident #9) in a sample of 9 residents who met the criteria for dental status and services.						
			E025	70	E279 Davelon Comprehensi	ivo.	10/22/2011
			F0279		F279 Develop Comprehensive Care Plan  Resident (#9) saw the dentist 9/22/11 and currently has no unmet dental needs.  100% audit will be conducted by 10/23/11 of active		10/23/2011
	Findings include	:			medical records by the Direc Nursing or designee to determine any unmet dental	tor or	
	reviewed on 9/21 Diagnoses include to, high blood pro amputation, must history of joint re no specific care p	rd for Resident #9 was /11 at 9:30 a.m. led, but were not limited essure, above the knee cle weakness and a eplacement. There was blan related to oral care, entures located in the			needs.  Licensed nursing personnel will be in-serviced SDC by 10/23/11 on conducting complete and accurate oral assessments based on the Nachedule utilizing the Oral Assessment Form and MDS schedule.  Staff Development Coordinates	by 1DS	

IDENTIFICATION NUMBER. 155266 INTELLY PROPERTY STATE. 2010 1992/3/2011  NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF FORT WAYNE  USUNABAY STATEMENT OF PERCEDENT BY FULL PROPERTY EACH DEPRICENCY MIST BE PERCEDED BY FULL REALLY TON YOU HAVE IN THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICENCY MIST BE PERCEDED BY FULL OR PREPRY EACH DEPRICENCY MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICENCY MIST BE PERCEDED BY FULL OR PREPRY EACH DEPRICENCY OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICENCY MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICENCY OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICENCY OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE ON THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST BE PERCEDED BY FULL PROPERTY EACH DEPRICE OF THE MIST EACH DEPAIR	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF FORT WAYNE  LIFE CARE CENTER OF FORT WAYNE  SIMMARY STATIMIST OF DIERCIENCIES  PREFIX  GACH DEFICIENCY MUST BE PRECEDED BY PULL  REQUILATORY OR LISC IDENTIFYING BROSMATION)  TAG  REQUILATORY OR LISC IDENTIFYING BROSMATION)  TAG  Clinical record during a review of the current care plans.  The Minimum Data Set (MDS)  Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not trigger for care planning. The MDS further indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident #9, dated 4/12/11, indicated the resident had inflammation and plaque and needed to return to the dentist by 7/12/11. The note further indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment.  A nurse's note, dated 4/12/11 at 10:20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit report for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident had 5  STRILT ADDRESS, CITY, STATE, JPP COME TAG PROFMATION PROFIXE PROFMATION PREFIX PAPPINGENE PROFMATION TAG  Will educate newly hired licensed personel during orientation on accurate completion of the Cral Assessment Form.  - The MDS Coordinator will utilize the Oral Assessment Form and review the resident shall summary from the last dental visit to ensure accuracy and completeness of the Oral Assessment Form and review the resident had inflammation and plaque and needed to report the dentile visit to ensure accuracy and completeness of the Oral Assessment Form sand that aligned and propriately.  - Nursing administration will be responsible for assuring the accuracy and completene	AND PLAN	OF CORRECTION		A. BUI	LDING	00		
LIFE CARE CENTER OF FORT WAYNE  LIFE CARE CENTER OF FORT WAYNE  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  CINICAL PROGRAM STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The Minimum Data Sct (MDS) Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not triager for care planning. The MDS further indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident had inflammation and plaque and needed to return to the dentist by 7/12/11. The note further indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment.  A murse's note, dated 4/12/11 at 10:20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident service and the dental service and the			133200	B. WIN			09/23/2	011
LIFE CARE CENTER OF FORT WAYNE   SUMANEY STATEMENT OF DEFICIENCIES   D RECENT OF SUBJECT OF SUPPLIES   D RECENT OF SUPP	NAME OF I	PROVIDER OR SUPPLIEF	8					
REFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION)  Clinical record during a review of the current care plans.  The Minimum Data Set (MDS) Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not trigger for care planning. The MDS further indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident #9, dated 4/2/11, indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, The note further indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment.  A nurse's note, dated 4/12/11 at 10/20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident had 5	LIFE CAI	RE CENTER OF FO	ORT WAYNE					
REFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION)  Clinical record during a review of the current care plans.  The Minimum Data Set (MDS) Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not trigger for care planning. The MDS further indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident #9, dated 4/2/11, indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, The note further indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment.  A nurse's note, dated 4/12/11 at 10/20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident had 5	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
clinical record during a review of the current care plans.  The Minimum Data Set (MDS)  Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not trigger for care planning. The MDS further indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident #9, dated 4/12/11, indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident had inflammation and plaque and needed to return to the dentist by 7/12/11. The note further indicated the resident needed pre-medication before returning for visit.  Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment.  A nurse's note, dated 4/12/11 at 10:20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident needs.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident had 5					PREFIX			
current care plans.  The Minimum Data Set (MDS)  Assessment for Resident #9, dated 4/7/11, did not indicate any dental concerns and the dental status did not trigger for care planning. The MDS further indicated the resident did not have any problems with short or long term memory.  A dental visit report for Resident #9, dated 4/12/11, indicated the resident did not he dentist by 7/12/11. The note further indicated the resident defention before returning for visit.  Oral Assessment Form (3/21/11, 4/5/11, 5/13/11, 7/7/11) indicated Resident #9 had both upper and lower partials. The form was incomplete for which teeth were missing. No particular concerns were noted on the assessment.  Oral Assessment Form (3/21/11 at 10:20 p.m., indicated a new order for a medical consult for possible pre-medication before next dental visit for Resident #9 due to a history of knee joint replacement.  A dental visit report for Resident #9, dated 9/22/11, indicated the resident had 5	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE	DATE
	TAG	clinical record decurrent care plant.  The Minimum D. Assessment for I did not indicate at the dental status planning. The M resident did not I short or long term.  A dental visit repedated 4/12/11, in inflammation an return to the denfurther indicated pre-medication by the companies of the companies of the companies of the consult for possion next dental visit repeats of the consult for possion next	partial set (MDS) Resident #9, dated 4/7/11, any dental concerns and did not trigger for care MDS further indicated the have any problems with m memory.  Poort for Resident #9, adicated the resident had d plaque and needed to tist by 7/12/11. The note the resident needed before returning for visit.  It Form (3/21/11, 4/5/11, indicated Resident #9 and lower partials. The plete for which teeth were ticular concerns were essment.  Interest desident #9 and lower partials are designed to a coint replacement.		TAG	will educate newly hired licensed personnel during orientation on accurate completion of the Oral Assessment Form - The MDS Coordinator will use the Oral Assessment Form a review the resident's dental summary from the last dental summary from the last dental to ensure accuracy and completeness of the Oral Assessment Form based on schedule. Any inconsistencie unmet needs will be reported to the physician and Director of Nursing for appropriate follow up.  4. Nursing Administration will responsible for assuring the accuracy and completeness Oral Assessment Forms and all dental needs are care planned appropriate - Nursing administration will a 100% of oral assessment for dental visits, and dental care plans weekly X 90 days to er compliance. Findings will be brought A go 100% compliance to the PI committee monthly with track and trending discussed. A goal of 100% compliance to the PI committee monthly with track and trending dental needs > 2 days will be achieved. Once 100% compliance is achieve Committee will then monitor quarterly to assure continued compliance.	n. Itilize Iti	DATE
		· ·				•		

PRINTED: 11/02/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			(X2) MULTIF A. BUILDING B. WING		DO	(X3) DATE S COMPL 09/23/20	ETED
	ROVIDER OR SUPPLIER		STT 16	49 SPY	DRESS, CITY, STATE, ZIP CODE RUN AVENUE YNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0280 SS=D	During the intervitives having proble both upper and be a second be a second be a second be a second both upper and be a second be a second be a second be a second both upper and be a second both upper and be a second both upper and be a second be a se	the right, unless adjudged nerwise found to be er the laws of the State, to ning care and treatment or not treatment.  care plan must be days after the completion sive assessment; prepared nary team, that includes the n, a registered nurse with the resident, and other in disciplines as determined eeds, and, to the extent articipation of the resident, ly or the resident's legal diperiodically reviewed and of qualified persons after	F0280		F 280 Right to Participate Planning Care for activities. Completed		10/10/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155266 09/23/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the activity care plan of 1 of 3 sampled 10/10/11 by Activities Director. residents (Resident #67) reviewed for ·Care plans reviewed by activities of the 10 residents who met the the Activities criteria for activities. Director for change of condition of resident and Findings include: appropriate goals and approaches on 10/10/11 1.Activities Director was Review of the clinical record for Resident reeducated by the Executive #67 on 9/21/11 at 9:25 a.m., indicated the Director on 10/3/11 on change following: diagnoses included, but were of condition, new not limited to, Down's Syndrome and admissions and quarterly assessments: presenile delirium. - MDS Coordinator will ensure change of The most current Activities Evaluation for condition is reported to each Resident #67, dated 5/13/10, indicated discipline and current activity preferences of changes to care plans are initiated within animals/pets, arts/crafts, beauty/barber, seven days of change. cards, community outings, educational ·Quarterly assessments programs, exercise, family/friend visits, will include an audit group discussion, movies, music, radio, of each disciplines care plans reading, religious services, religious by the Activity Director or designee. studies, sing-along, social/parties, - Activities Director will television, and walking. complete reviews of care plans monthly prior to An Activity Progress Notes for Resident **Process** #67, dated 8/23/11, indicated she Improvement Meeting and propelled herself via wheelchair and report any issues. 4. Activities Director will needed escorts to activities. The Activity complete audit of care plans Progress Notes also indicated Resident based on MDS schedule and #67 passively attended group activities significant change and report such as morning stretch, arts and crafts, concerns weekly X 90 days to sensory group, cooking group, religious ensure compliance. - Findings will be brought to the PI services, women's group and special Committee monthly with tracking and events/parties. The Progress Note further trending discussed. A goal of 100%

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2)	MULTIPLE CON			(X3) DATE S COMPLE		
AND PLAN	OF CORRECTION	155266		UILDING	00		09/23/20	
		100200	В. W	VING			03123120	, i i
NAME OF F	PROVIDER OR SUPPLIER	3			DDRESS, CITY, STATI	E, ZIP CODE		
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(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		ı	(X5)
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TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	)	TAG	CROSS-REFERENCED DEFICIE	TO THE APPROPRIAT ENCY)	E	DATE
	indicated Resident #67's independent activities included movies, television, friend/family visits, visits from peers and staff, and listening to music.				compliance with o			
					activities X90 day Once 100% comp			
					PI Committee will	then monitor	,	
					quarterly to assur compliance.	e continued		
					5. Date of Comple			
	1	lan for Resident #67, with			·Resident (#6	•		
		11/11, indicated the			Interdisciplinary Meeting schedu		<sub>/11</sub>	
	1 *	need of individualized			to update activi	ty care plan.		
		oaches to the problem				ere reassesse	d	
	-	ere not limited to, sensory			and care plans	updated		
		rities will be offered and						
	small sensory gro	oups.						
	A £:1:4 A -4::4	tion Calcadala for						
	A facility Activit							
		, provided by the Activity						
	Director on 9/22/	• .						
		lowing: on 9/20/11,						
	•	at 9:30 a.m., music with ted) at 10:00 a.m., and						
	`	m.; on 9/21/11, morning						
		m., trivia at 11:00 a.m.,						
		basketball at 1:30 p.m.;						
	_	sory group at 9:30 a.m.,						
	1	a.m., and horseshoes at						
	2:00 p.m.	,						
	A facility Individ	dual Resident Daily						
	Participation Rec	cord for Resident #67, for						
	_	otember 2011, indicated						
		icipated in current						
		9/20/11 and on 9/21/11,						
	1	pated in exercise on						
	_	sively participated in						
	group discussion	n on 9/20/11 and 9/21/11.						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	1U7V′	11 Facility II	D: 000167	If continuation sh	neet Pag	e 12 of 32

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
11112 12111	or condition	155266	A. BUIL B. WING			09/23/2	
			B. WINC		DDRESS, CITY, STATE, ZIP CODE		
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TAG		<u> </u>		IAG	BEIGERC1)		DATE
	_	n Record also indicated icipated in movies, music,					
	1						
	radio, and television in her room on 9/20/11 and 9/21/11. The Participation						
		ndicate Resident #67					
		music with (name 9/20/11 at 10:00 a.m.,					
	· · · · · · · · · · · · · · · · · · ·	1 at 2:00 p.m., and trivia					
	_	:00 a.m. No entries had					
		e Participation Record for					
		nt #67 was not observed					
		the scheduled activities					
	· ·	rning stretch at 9:30 a.m.,					
	,	ne documented) at 10:00					
		at 2:00 p.m.; 9/21/11,					
	_	at 9:30 a.m., and trivia at					
	•	/11, sensory group at 9:30					
		Chapel at 10:00 a.m., and					
		00 p.m. Resident #67 did					
	1	ndividualized activities					
	during this time.						
	The Activity Dir	rector was interviewed on					
	1	o.m. During the interview					
		ident #67 did not do well					
	with individualiz	zed activities and she was					
	to continue with	active or passive					
		group activities. The					
		n did not reflect the					
	change.						
	_	y policy " Resident Care					
	Plan", revised 12	2/08, indicated "Review					
	of the care plan	is done at least quarterly					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/23/2011
	ROVIDER OR SUPPLIER		STREE 1649	T ADDRESS, CITY, STATE, ZIP CODE SPY RUN AVENUE F WAYNE, IN46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	and as needed to reflect the resident's current needs, problems, goals, care, treatment, and services"				
	3.1-35(d)(2)(B)				
F0282 SS=D	facility must be proin accordance with plan of care. Based on record facility failed to a follow up was considered as care planned for reviewed for pair sample of 6 residues.	ded or arranged by the ovided by qualified persons in each resident's written review and interview, the ensure pain assessment impleted for PRN meds for 1 of 3 residents in (Resident #9) in a lents who met the criteria ion and management.	F0282	F282 Services by Qualified Persons/Per Care Plan - Health Information Manag will audit Medication Administration Record boo with monthly Medication Record change out to assur Pain Flow Sheets are place in the Medication	ks

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE S COMPLE 09/23/20	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF 1	PROVIDER OR SUPPLIER	t			PY RUN AVENUE		
	RE CENTER OF FO				VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
	Findings include	:			Administration Books. Residents that are		
					started on as needed pain		
		ord for Resident #9 was			medications within the mor will	nth	
	reviewed on 9/21	1/11 at 9:30 a.m.			be identified by physician's	,	
	Diagnoses include	led, but were not limited			orders and the DON or		
	to, high blood pr	essure, above the knee			designee		
	amputation, mus	cle weakness and a			will assure a Pain Flow She implemented by performing		
	history of joint re	eplacement.			- Twice weekly a 100% audi	- 1	
					Pain Flow Sheets to assure		
The PRN (as needed) Medication					forms are		
Administration Record (MAR) for June				being utilized correctly. The			
	2011, indicated there was an order for				DON will review audits wee	kly	
	acetaminophen (	pain reliever) to be given			and provide further education and/or		
	1	as needed for pain. The			disciplinary action as need	ed.	
	1 *	taff was to document on			- Findings will be brought to		
	the pain flow she	eet. The MAR indicated			the PI Committee monthly v	with	
	_	received the pain			tracking and trending		
		/8/11 at 11:00 a.m. There			discussed. A goal of 100%		
	was no documen	tation on the flow sheet			compliance with correct utilization of th		
	to indicate the lo	cation of pain or the			Pain Flow Sheet X 90 days		
	intensity of the p	-			be		
					achieved. Once 100%		
	The PRN MAR	for June 2011, indicated			compliance is achieved, PI		
		er for ultram (pain			Committee will then monitor quarterly	to	
		ven three times a day as			assure continued complian		
	1	The order further			1.Date of Completion:		
	_	as to document on the			10/23/11		
	pain flow sheet.	The record indicated			·A pain assessment was		
	1 ^	received the pain			completed on 9/29/11 on resident (#9) and the resider	<sub>nt</sub>	
		/8/11 at 1:10 p.m.,			was found to be	"	
		o.m., and 6/22/11 at 11:00			pain free.		
	_	no documentation			·A 100% audit of active	ion	
		cation of pain, intensity of			residents PRN Pain Medicat	IUII	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI  OO COMPLE					
AND PLAN	OF CORRECTION	155266	A. BUI	LDING	00	09/23/2	
		130200	B. WIN			09/23/2	UII
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LIEE CA	RE CENTER OF FO	DRT WAYNE			PY RUN AVENUE VAYNE, IN46805		
			ı	<u> </u>	v/ \		are:
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TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
		*		1110	Administration Records will b	<u></u>	Diffe
	pain, or effectiveness of the medication for 6/8 and 6/15. There was no				completed by 10/23/11		
		o indicate the location of			by Nursing Administration ar		
		sity of the pain for 6/22.			Pain Flow Sheets (LCAA – 5	25)	
	pain of the intens	sity of the pain for 6/22.			have been implemented on 10/12/11		
	The DDN MAD	for July 2011 indicated			·The form: Pain Flow Shee	t	
		for July 2011, indicated			(LCAA – 525) will be		
		er for Tramadol (pain			implemented every time a		
	· · ·	e given three times a day			resident receives pain medication to assure		
	•	in. The order further			documentation of location ar	ıd	
		as to document on the			intensity of pain and effective	eness	
	•	The record indicated			of medication given		
		received the pain			is correct.	1	
		21/11 at 2:30 a.m. There			<ul> <li>Licensed nursing personne be in-serviced by</li> </ul>	I WIII	
		tation to indicate the			the Staff Development		
	_	ain or the intensity of the			Coordinator by		
	pain.				10/23/11 on completing the F	Pain	
	The DDNIMAD.	for Comtourless 2011			Flow Sheet Staff Development Coordin	ator	
	indicated there w	for September 2011,			will educate		
					newly hired licensed personr	nel	
	_	o be given every four			during orientation		
		for pain. The order			on completing the Pain Flow Sheet.		
		staff was to document on			·Monitoring to ensure alleg	ed	
	_	eet. The record indicated			deficient practice does not re		
		received the pain					
		/1/11 at 11:00 a.m.,					
		m., and 9/5/11 at 10 (no					
	am or p.m. listed						
		o indicate the location of					
	the pain or the in	itensity of the pain.					
	The engineers of the	nlan farmain datad					
		plan for pain, dated					
	· ·	ed "assess location,					
		ion and intensity of					
	paindocument	assessmentdocument					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	(X2) MU  A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPLI 09/23/20	ETED
	VIDER OR SUPPLIER	RT WAYNE	S. WIIIC	STREET AI	DDRESS, CITY, STATE, ZIP CODE Y RUN AVENUE AYNE, IN46805		
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F0309 SS=D mtc plin as B fa	n 9/21/11 at 1:10 nterview, she incheet is filed with dministration reshould be signed iven for and its of the control of the clinical record resident must provide the notation or maintain hysical, mental, an accordance with seessment and placed on record recording to the control of the clinical recording include:  The clinical record recording include:	at receive and the facility ecessary care and services in the highest practicable and psychosocial well-being, at the comprehensive lan of care.  The review and interview, the ensure pain assessment impleted for PRN meds for 1 of 3 residents in (Resident #9) in a ents who met the criteria fron and management.	F03	309	F309 Provide Care/Service of Highest Well Being - Health Information Manage will audit Medication Administration Record Books with monthly Medication Administration Record change out to ensure Pain Flow Sheets are placed in the Medication Administration Books. Residents that are started of as needed pain	er , ne	10/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1U7V11 Facility ID:

000167

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	COMPL	ETED
		155266	B. WING	3 <u> </u>		09/23/2	U11
	PROVIDER OR SUPPLIER		Ī	1649 SP	DDRESS, CITY, STATE, ZIP CODE YY RUN AVENUE /AYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	Diagnoses included to, high blood property amputation, musch history of joint results of the PRN (as need Administration Results and the pain flow sheed Resident #9 had medication on 6/was no document to indicate the local intensity of the pain flow sheed for pain, indicated staff was an order to be given be	led, but were not limited essure, above the knee cle weakness and a eplacement.  ded) Medication decord (MAR) for June there was an order for pain reliever) to be given as needed for pain. The taff was to document on the taff was to document on the tation on the flow sheet cation of pain or the tation of pain or the tation on the flow sheet cation of pain or the tation.  For June 2011, indicated the pain (Pain the tation on the flow sheet cation of pain or the tation of the tation on the flow sheet cation of pain or the tation of the tation on the flow sheet cation of pain or the tation of the tation on the flow sheet cation of pain or the tation of the flow sheet cation of pain or the tation of the flow sheet cation of the flow sheet cation of the flow sheet cation of pain, and 6/22/11 at 11:00 no documentation ation of pain, intensity of the medication		TAG	medications within the mowill be identified by physicorders and the DON or designed assure a Pain Flow Sheet implemented.  Twice weekly 100% audit of Pain Flow Sheets to ensurforms are being utilized correctly.  DON will review audits twiceweekly and provide further education and/or disciplinaction as needed.  - Findings will be brought the PI Committee monthly tracking and trending discussed. A of 100% compliance with correct utilization of the Pain Flow Sheet X90 days will be achieved. Once 100% compliance is achieved. Once 100% addit of active residents PRN Pain Medical Administration Records will completed by Nursing Administration by 10/23/11 Pain Flow Sheets (LCAA — will be implemented on 10/2 Systems to ensure alleged deficient practice does not resident practice d	nth ian's vill s vill s of e the ce ary to with goal ved nitor ued 23/11 on s tion be and 525) 3/11 d	DATE
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	 1U7V11	Facility II	·		ge 18 of 32

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/23/2	ETED	
NAME OF PROVIDE			•	1649 SF	DDRESS, CITY, STATE, ZIP CODE PY RUN AVENUE VAYNE, IN46805		
· ·	EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
there medi as ne indic pain Resid medi was ne locat pain.  The I indic aceta hours furth the p Resid medi 9/5/1 am o docur the p  The o 2/16/ frequencial frequencial forms of the pain.	e was an order cation) to be reded for pair ated staff was flow sheet. It dent #9 had a cation on 7/mo documention of the pair ated there was as needed at a redefined at 7:00 a.r. r.p.m. listed mentation to a ain or the incurrent care a cation on the incurrent care and cation on the incurrent care are care and cation on the incurrent policies are cational cation of the pair and cation on the incurrent policies are cational cation. It is a cation of the pair and cation on the incurrent care are cational cation on the incurrent policies are cational cation. It is a cation of the pair and cation of the pair and cation on the incurrent care are cational cation of the pair and cation on the pair and ca	for July 2011, indicated er for Tramadol (pain e given three times a day in. The order further as to document on the The record indicated received the pain 21/11 at 2:30 a.m. There tation to indicate the ain or the intensity of the for September 2011, as an order for to be given every four for pain. The order staff was to document on the et. The record indicated received the pain 1/11 at 11:00 a.m., and 9/5/11 at 10 (no for the indicate the location of the indicate the location of the pain to of the pain.  There was no for indicated dresses should be pain to pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain, dated dresses should be pain.  The plan for pain at the pain to pain, dated dresses should be pain.			- The form: Pain Flow Sheet be implemented every time a resident receives as needed medication to assure documentation of locations a intensity of pain and effectiveness of medication g is correct.  - Licensed nursing personne be in-serviced by the Staff Development Coordinator on completing Pain Flow Sheet 10/23/11.  - Staff Development Coordination will educate newly hired licer personnel during orientation completing the Pain Flow Sh Monitoring to ensure alleg deficient practice does not re	pain  nd  iven  will  by  ator  sed  on  eet. ed	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			A. BUILDIN		STRUCTION  00	(X3) DATE S COMPLI 09/23/20	ETED
	ROVIDER OR SUPPLIER		1	649 SPY	DDRESS, CITY, STATE, ZIP CODE Y RUN AVENUE		
LIFE CAP	RE CENTER OF FO			ORI W	AYNE, IN46805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	"nursing staff v document the eff management programedical record been identified to their pain assesse to include vital si this assessment a placed on the Pair An interview was on 9/21/11 at 1:1 interview, she income sheet is filed with administration re	gram in the resident each resident who has have pain will have ed at least once per shift gnsdocumentation of nd vital signs will be n Flow Sheet"  s conducted with LPN #1 5 p.m. During the dicated the pain flow n the medication cord (MAR). The record as given, what it was					
F0323 SS=E	environment rema hazards as is poss	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents.					
	Based on record interview the factorise (resident #12) was device to prevent	review, observation, and ility failed to ensure 1 as provided an assistive falls as care planned in a ents reviewed for falls in	F032	3	F 323 Free of Accident Hazards/Supervision/Device Findings will be brought to PI Committee monthly withtracking and trending discussed. A goal of 100% compliancewith consistent		10/11/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		ĺ	UILDING 00 COMPLETE		(X3) DATE SURVEY  COMPLETED  09/23/2011	
		<u> </u>	J. 1711		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER	3			PY RUN AVENUE	
	RE CENTER OF FO			<u> </u>	VAYNE, IN46805	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		TAG	temperatures will be achiev	
	_	lents who met the criteria			Once 100% compliance is	reu.
		the potential to affect 1			achieved, PI Committee wil	I
		om. The facility further			then monitor quarterly to	
		not water temperatures in			assure continued complian	ce.
	3 of 10 resident	room bathrooms observed			.5. Date of Completion:	
	for proper water	temperatures were			10/11/11	
	maintained betw	een 100 and 120 degrees			·Mixing valves replaced on	
	Fahrenheit (roon	n 44, room 30, and room			boilers 9/19/11.Water heater replaced on 9/26/11 on Pres	
	111) having the	potential to affect 3			Hall Flooring in bathroom o	
	residents (Reside	ent ##71, Resident #13,			room for resident#12 was	
and Resident #48).					replaced on 9/26/11. Non	
		- )-			skidstrips were applied on	
	Finding includes				9/23/11 and reappliedto new	
	I manig merades	•			flooring ·An audit of non skid strips	in
	1 Davison of 4h	aliniaal maaaad Can			relation to thecare guide was	
		e clinical record for			completed on 9/23/11 with	
		9/21/11 at 10:00 a.m.			nofurther issues noted Dail	y
		ident had a fall on			water temperature checks	
	_	o.m. Review of the			completed byMaintenance	
		d the resident was found			Director with no other fluctuationsnoted.	
		s bathroom, and had			·Maintenance Director che	cks
	sustained rednes	s to his back. The			water temperaturesweekly w	
	resident stated he	e tried to go to fast.			any deviations to approved	
					temperaturesrelayed to the	
	Interview with the	ne DON (Director of			Executive Director and adjustments made Direct C	aro
	Nursing) on 9/21	/11 at 10:30 a.m.			staff tests water before use of	
	· · · · · · · · · · · · · · · · · · ·	ident had a personal			every occasionof resident ne	
		nproved (with therapy)			and any deviation from appro	
		d been discontinued. The			temperaturesis reported to the	ne
		d the personal alarm at			Maintenance Director and	
	this time.	- me personal alaim at			Executive Director Staff in-serviced by Maintenance	
	dis time.				Director on 10/11/11on report	rtina
	Davious of the al	inical record indicated a			fluctuations in water tempera	
					and when to report to	
	_	indicated the resident was			Maintenance and the Execut	
	at risk for falls re	elated to a history of falls,			Director to ensure noresiden	ts

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155266	B. WIN	G		09/23/2	011
NAME OF I	PROVIDER OR SUPPLIER	<b>\</b>			ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAI	RE CENTER OF FO	DRT WAYNE			PY RUN AVENUE VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	NO AMERICAN AND GOVERNO		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hemiplegia from	a cerebral vascular			use water until safely regulat		
	accident (stroke)	and decreased mobility.			<ul> <li>Water temperature audits be monitored weekly to assu</li> </ul>		
	The goal was the	e resident would have			temperatures are remaining		
	limited injury fro	om falls through			consistent.		
		. An intervention dated			·Care guides are reviewed		
	6/21/11 was for	the resident to have			Medical Records daily to ens they match new and existing	ure	
	non-slip strips or	n the floor in front of the			orders for assistive devices.		
	toilet.				Department Heads are assig	ned	
					halls for daily review of the ca		
	Observation of t	he resident's room on			guide to ensure assistive devare in place. The Maintenan		
	9/21/11 at 11:00	a.m. revealed there were			Director is responsible for	Ce	
	no non-slip strip	s in front of the toilet.			ensuring assistive devices ar	e	
	The director of r	nursing was queried about			moved to the new room when		
	the lack of floor	strips, and called the			resident is transferred. Assis devices are also reviewed du		
	maintenance sup	ervisor to the resident's			care plan meetings quarterly		
	room. The Mair	ntenance Director		a resident has a fall. The Fall			
	indicated there h	ad been non-slip strips in			Committee writes		
	front of the toile	t but indicated the		recommendations during the			
	linoleum in the b	oathroom was "bad" and			weekly meetings and assistive devices are written as orders		
	the strips did not	always stick.			placed in the Work Order Bo		
					for the Maintenance Director	or	
	Interview with re	esident #12 on 9/22/11 at			designee to install.		
	1:30 p.m. indica	ted there had been strips					
	on the floor in th	e bathroom but indicated					
	"they don't stick	."					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C	00	COMP	
		155266	A. BUILDING B. WING		09/23/2	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			SPY RUN AVENUE		
LIFE CAF	RE CENTER OF FO	ORT WAYNE	FORT	WAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFY ING INFORMATION)	TAG	DEFICIENCE)		DATE
	2. On 9/19/11 at	: 12:30 P.M., during an				
		oom 30, Resident #13's				
		rature of the hot water in				
	the hand washing	g sink in the bathroom				
	felt very hot to the	ne touch. A digital				
	thermometer was	s then used to determine				
		rature of the hot water.				
	_	nometer registered a				
	temperature of 12	28.4 degrees Fahrenheit.				
	0.0/10/11 : 13	25 D.M. 1				
		:35 P.M., during an				
		oom 111, Resident #48's				
	_	rature of the hot water in g sink in the bathroom				
	felt hot to the tou	-				
		s then used to determine				
		rature of the hot water.				
	_	nometer registered a				
	-	30.1 degrees Fahrenheit.				
	timpolatare of 1.	a con a contraction of the contr				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		(X2) MULTIPLE  A. BUILDING  B. WING	00	COM	ie survey ipleted 3/2011	
	PROVIDER OR SUPPLIER		1649	T ADDRESS, CITY, STATE, ZIP SPY RUN AVENUE F WAYNE, IN46805	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	temperatures were and room 111 by director using a comprovided by the froom 30 was 119 the hot water tem was 119 degrees interview with the indicated he had adjusted to downward.  On 9/19/11 at 2:3 observation of room, the temperature with hand washing felt hot to the tou Maintenance Directory temperature with and noted that the was fluctuating to degrees Fahrenhowith the Maintenindicated he thou problem with the would attempt to temperature dow staff were instructive water on the affective of the provided in the formula of the problem with the would attempt to temperature dow staff were instructive water on the affective provided by the provided in the problem with the would attempt to temperature dow staff were instructive water on the affective provided by the provided	ector checked the water a digital thermometer hot water temperature between 134 and 138 eit. During an interview hance Director, he hight that there might be a mixing valve, but he hadjust the water h. He indicated facility heted not to use the hot				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266			(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/23/2011
	PROVIDER OR SUPPLIER		1649 S	ADDRESS, CITY, STATE, ZIP CODE SPY RUN AVENUE WAYNE, IN46805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	_	per was scheduled to ity later that day to check			
F0412 SS=D	from an outside re §483.75(h) of this covered under the emergency dental of each resident; n the resident in mal arranging for trans dentist's office; an residents with lost dentist.  Based on record facility failed to 61 of 3 residents	services to meet the needs nust, if necessary, assist king appointments; and by sportation to and from the d must promptly refer or damaged dentures to a review and interview, the obtain dental services for reviewed for dental	F0412	F412 Routine/Emergency Dental Services in NFS Resident (#9) was seen by dentist on 9/22/11 and	10/06/2011 y the
	residents who me status and service Findings include The clinical recoreviewed on 9/21 Diagnoses include to, high blood presidents.	: rd for Resident #9 was		has no unmet dental needs.  2. PrimeSource dental service have been reinstated in facility effective 10/6/11. residents will be seen in-hou PrimeSource quarterly and as needed.  3. Social Services Director in conjunction with Nursing Administration will review de orders and physician orders Monday through Friday to en any resident identified to have	ntist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
						09/23/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					PY RUN AVENUE		
LIFE CARE CENTER OF FORT WAYNE				FORT V	VAYNE, IN46805		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	need		DATE
		eplacement. No notes			is seen by the dentist as soo	n as	
		e social services section		possible Residents who complain of oral			
	_	rding any concerns with					
	obtaining a denti	ist.			problems will be scheduled		
					to see the PrimeSource dent	ist as	
		ted 9/19/11 at 3:00 p.m.,			soon as possible Social Services Director wil	ı	
		nt #9 "complained of			review monthly dental visit	•	
	discomfort while	e drinking cold fluids;			list with PrimeSource person	nel	
	states 'I feel a hole on the left side molar with my tongue'called (physician's name documented) office, made appointment				to ensure everyone is		
					seen appopriately.  4. Social Services Director w	ill	
					audit resident medical record		
	for 9/22/11. No other documentation was noted in the clinical record regarding the concern.  The dental visit record, dated 4/12/11,				with care plan meetings and		
					schedule to ensure resident Dental needs are met X90 da		
				Weekly audits X4 then weekly X2 and then monthly.			
		nt #9 had inflammation			Findings will be brought to the PI Committee monthly with tracking and trending discussed.		
		note further indicated no					
	prophy done, nee				A goal of 100% compliance		
		oremed and schedule			with meeting dental needs w achieved. Once 100%	III be	
	before 7/12/11.	stemed and semedate			compliance is achieved, PI		
	001010 //12/11.				Committee will then monitor		
	Δ nurse's note do	ated 4/12/11 at 10:20			quarterly to assure continued	d	
		MD consult, possible med			compliance	44.4	
	* .				5. Date of Completion: 10/23	/11	
	_	at dentists visit due to					
	knee joint replac	CHICHL.					
	A telephone orde	er dated 4/12/11					
	_						
	indicated MD consult, premed order for dental visits if ok with physician, clindamycin 600 mg 1 hour before visit.  An interview was conducted with						
		0/12/11 at 11:00 a.m.					
	Resident #9 on 9	1/12/11 at 11.00 a.m.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/23/2011				
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE  1649 SPY RUN AVENUE FORT WAYNE, IN46805					
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION			
TAG	During the intervindicated the den	riew, Resident #9 tist was supposed to have in July. She stated there	TAG	DEFICIENCY)	DATE			
	was a whole list seen in July but l	of people that were to be Medicaid insurance had weren't seen. She stated						
	dentist, one that	ald have to go out to the accepts Medicaid.						
	Staff Developme 9/12/11 at 11:00 interview, she in	s conducted with the ent Coordinator on a.m. During the dicated there was nothing ring the premed had been						
	Services on 9/23, the interview, So the contract for of the end of May. facility is now sedentist that accept they are currently different dentists	s conducted with Social /11 at 10:45 a.m. During scial Services indicated lental services was out She further indicated the ending residents out to the ots Medicaid. She stated y using at least three and the facility is nents as they are needed.						
	3.1-24(a)(1) 3.1-24(a)(2) 3.1-24(a)(3)(b)							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155266 09/23/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1649 SPY RUN AVENUE LIFE CARE CENTER OF FORT WAYNE FORT WAYNE, IN46805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must maintain clinical records on F0514 each resident in accordance with accepted SS=D professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. F514 F0514 10/23/2011 Records-Complete/Accurate/Ac Based on observation, interview and cessible record review the facility failed to ·Resident (#67) had medical accurately record attended activities of 1 record reviewed and corrected of 3 sampled residents (Resident #67) to reflect current status (10/3/11). ·Resident (#23) Restraint reviewed for activities of the 10 residents release is monitored by who met the criteria for activities. The Licensed personnel daily and is facility further failed to document release now being recorded daily and of restraint for 1 of 1 residents reviewed documented on the resident's Medication Administration for restraint (Resident #23) in a sample of Record. 1 residents who met the criteria for 1.Activities Director or potential restraints. designee will audit 100% of participation logs weekly X4 then weekly X3 Findings include: then weekly X2 and then monthly. 1. Review of the clinical record for Licensed personnel will audit Resident #67 on 9/21/11 at 9:25 a.m., 100% of restraint release documentation on the MAR indicated the following: diagnoses weekly X4 then weekly X3 then included, but were not limited to, Down's weekly X2 and then monthly. Syndrome and presenile delirium. 3. Activities Staff in-serviced on proper documentation of the participation A facility Activities Evaluation for Resident #67, dated 5/13/10, indicated 10/5/11 by Executive Director. current activity preferences of Licensed personnel will be

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION  OO			(X3) DATE SURVEY COMPLETED		
		155266		LDING		09/23/2		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1649 SPY RUN AVENUE				
LIFE CAR	RE CENTER OF FO	ORT WAYNE			VAYNE, IN46805			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG				TAG	in-serviced by SDC on 10/11	/11	DATE	
	•	s/crafts, beauty/barber, ry outings, educational			regarding appropriate	, , ,		
	•	ise, family/friend visits,			documentation of the restrain	nt		
		n, movies, music, radio,			records on MAR. 4. Activities documentation audit and restraint release			
		s services, religious						
	•	ng, social/parties,			audit will be included in Pl			
	television, and w				meetings next 90 days.	ъ.		
	toro vibron, and w	, w.m.115.			Findings will be brought to the PI Committee monthly with			
	The Activity Dir	rector was interviewed on			tracking and trending discus	sed.		
	9/22/11 at 1:56 p.m. During the interview				A goal of 100% compliance			
	he indicated activity staff were				with meeting dental needs w	ill be		
		ecording the attendance			achieved. Once 100% compliance is achieved, PI			
	•	on the Individual			Committee will then monitor			
	Resident Daily F	Participation Record. He			quarterly to assure continued	t		
	further indicated the letter A meant active participation, the letter P meant passive participation, the letter R meant refused, and the letter U meant unable.				compliance Date of Completion: 10/23/11			
					Date of Completion. 10/23/1	1		
	-	ties Schedule for						
	•	, provided by the Activity						
		/11 at 1:56 p.m.,						
		lowing: on 9/20/11,						
	•	at 9:30 a.m., music with						
	*	ted) at 10:00 a.m., and						
		m.; on 9/21/11, morning						
		m., trivia at 11:00 a.m., basketball at 1:30 p.m.;						
	-	sory group at 9:30 a.m.,						
		, ,						
	chapel at 10:00 a.m., and horseshoes at 2:00 p.m.							
	2.00 p.m.							
	A facility Individ	dual Resident Daily						
	•	cord for Resident #67, for						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  00	COM	ee survey ipleted 5/2011	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP CODE  1649 SPY RUN AVENUE  FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	she actively particle events/news on 9 passively particle 9/20/11, and passing group discussion. The Participation she actively particle active particle active active particle acti	at #2 was interviewed on .m. During the interview					

Facility ID:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266	(X2) MU A. BUII B. WIN	DING	NSTRUCTION  00	(X3) DATE : COMPL <b>09/23/2</b>	ETED
NAME OF B	ROVIDER OR SUPPLIER		B. WIN		DDRESS, CITY, STATE, ZIP CODE		
LIFE CARE CENTER OF FORT WAYNE					PY RUN AVENUE		
				l	VAYNE, IN46805		(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	was observed in magazine with a her wheelchair.  A telephone order 12/14/10, indicate positioned in her lap tray for no magazine with a positioned in her lap tray for no magazine. The current care d/t (due to) need rising," dated 12/2 the resident was position every 30.  The September 2 Record," for Resident was position every 30.  The September 2 Record," for Resident was position every 30.  An interview was on 9/22/11 at 1:4 interview, LPN# documentation for be found in the behalministration Formal Position Formal Posi	her room reading a full lap tray in place on for Resident #23, dated the resident was to be wheelchair with a full ore than 2 hours.  plan for "At risk of injury for a chair that prevents /30/1899 (sic), indicated to be assisted to change minutes to 2 hours.  2011 "Restraint Release ident #23 was missing in 9 of 16 days reviewed to precise and/or release every seconducted with LPN #1 to p.m. During the 1 indicated for restraint release would book with Medication Records (MAR). A ord indicated there was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155266		(X2) MULTIPLE C	OONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  09/23/2011	
		100200	B. WING	ADDRESS, CITY, STATE, ZIP CODE	03/20/2011
NAME OF P	PROVIDER OR SUPPLIER	₹		SPY RUN AVENUE	
LIFE CAF	RE CENTER OF FO	ORT WAYNE	FORT	WAYNE, IN46805	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION DATE
_		on with the MAR for			
	release of the res				
	3.1-50(a)(1)				
	3.1-50(a)(2)				